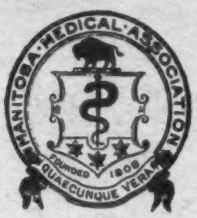

IN AFFILIATION WITH
THE CANADIAN MEDICAL ASSOCIATION
THE BRITISH MEDICAL ASSOCIATION

BULLETIN

of the

Manitoba Medical Association

December, 1933

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Editor—C. W. MacCHARLES Medical Historian—ROSS MITCHELL

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Medical Services for Citizens In Receipt of Unemployment Relief

Progress During Past Year

ABOUT a year has elapsed since the meeting of the medical profession of Greater Winnipeg, at which it was finally decided to attempt to make, with the various governments, some arrangement for providing medical services for citizens in receipt of relief funds. Although no final scheme for the care of relief cases has yet been arranged, certain definite principles have been established, and certain tangible advances have been made. When negotiations were first started, a great deal of delay was occasioned by the fact that it was impossible to find one of the governing bodies which would admit being constitutionally responsible for providing medical services for citizens in receipt of relief funds. However, on January 12th, 1933, a committee interviewed the Premier of Manitoba, the Honorable Mr. John Bracken, and also the Honorable Mr. R. A. Hoey, Minister of Education and Health and Public Welfare. At this meeting, the Premier admitted that the province could not escape the responsibility for providing medical services for citizens in receipt of relief funds. The acceptance of this principle was qualified, however, by the statement that the financial resources of the province would not allow it to provide funds for this purpose, and all that was promised was that the matter would be brought up at the Dominion-Provincial conference at Ottawa. This conference resulted in the statement to the press that, "in the opinion of the committee a limited expenditure for medical attention, where circumstances render such expenditure necessary, might be regarded as coming within the scope of the definition of direct relief." The progress, however, ended with the issuing of this statement, and no action was taken to put it into effect.

On February 25th, 1933, a plan for caring for relief cases was submitted to the Council of the City of Winnipeg, at its request. This plan, however, was merely pigeon-holed, and no action was ever taken. On April 15th, 1933,

the Winnipeg General Hospital closed its out-patient department because the funds of the institution did not allow it to carry on this service. This action was taken by the hospital authorities themselves for purely financial reasons. On June 1st, 1933, the medical practitioners in Manitoba finally decided they could no longer care for relief cases, excepting emergencies, and the authorities were advised to this effect. On July 1st, 1933, the honorary attending staffs of all the hospitals of Greater Winnipeg advised the hospitals that, except in cases of accidents and emergencies, they could no longer care for relief patients in the out-patient departments or wards of the hospitals. Except in the case of Victoria Hospital, this plan was carried out, but in December of this year the difficulties with this hospital were finally adjusted, after the honorary attending staff had resigned.

One of the difficulties continually encountered was that municipal and provincial authorities always insisted they could do nothing about relief cases without sanction by the Dominion Government. Finally, arrangements were made by the Canadian Medical Association to approach the Dominion Government. A meeting was held with the Prime Minister of Canada, the Right Honorable Mr. R. B. Bennett, on October 6th, 1933. The result of this interview was published in the November number of the *Bulletin*. Following this interview, a letter was sent to the Premiers of each of the provinces by the Dominion Government, a copy of which is contained in this issue of the *Bulletin*. This conference has finally settled the question as to the relative responsibilities of the Dominion, Provincial and Municipal authorities with regard to medical relief.

At the end of the present year, then, the situation is that the responsibilities of the various governing bodies, with regard to medical relief, has finally been established. The methods by which the authorities were able to avoid their responsibilities, by sending relief cases to hospitals and private practitioners, are now prevented. The medical profession, of course, still continues to look after cases which have been classed as emergencies, and the interpretation placed on this definition has been very generous.

In addition, certain tangible results have been obtained by the committee. In the first place, a temporary arrangement was made with the Provincial Government for the care of cases of venereal diseases among citizens on relief. This arrangement could never have been made had it not been for the negotiations of the central committee. Further, arrangements for medical services for people who are farming under the back-to-the-land scheme have been made on a fairly equitable basis. Medical services for single unemployed in the Dominion Government camps have been made on a basis which, under the circumstances, is not unreasonable.

The greatest result attained, however, has been the consolidation of opinion among medical practitioners. It was freely prophesied, when these negotiations were first started, that the medical profession would not act in consort. These prophesies have proved to be entirely false. The central committee has received the full and continuous support of all members of the profession. The time has been reached when the various governing bodies have come to realize that, in all negotiations with the medical profession, they will have to consult those who represent the considered opinion of the whole profession. The difficulties that the profession has encountered have developed an *esprit de corps*, which probably could never have been developed by any other circumstances. The medical men, in addition to bearing the burdens which are carried by all citizens at the present time, have continued to provide medical services in needy cases, even after it has been admitted that the responsibility of providing these services rests upon the various governments,

and the profession has continued to press for the provision of proper medical services for citizens in receipt of relief funds. The aim of the central committee has been to arrange a medical service which will be satisfactory to the profession and to the unemployed on relief, without imposing an unreasonable burden on the taxpayer. The profession is willing to contribute by way of service one-half the cost of such care during the present emergency by accepting as their fees half the established tariff rate. The financial resources of the profession are meagre, and its voting strength of no account. Hence its effective power in any democratically controlled country is negligible. But there is no doubt that, in the matter of medical relief, the considered opinion of the organized medical profession will ultimately receive the endorsement of the ultimate and most powerful court of appeal—public opinion.

If any scheme for medical services for people on relief were worked out with the authorities, the chief danger which would have to be avoided by the profession would be that of abuse of the system by individual members of the profession. Certain lay sources have freely expressed the opinion that any system of medical services, which has as a feature, free choice of doctor, will break down because the individual medical men will abuse this system. The feeling of the profession is quite definitely that the doctors will not abuse their privileges, and will live up to the spirit of any agreement that is made with the governments. The arrangements that have been made for medical care for people under the back-to-the-land scheme will serve as a test, and it is confidently expected that the medical men who will be called upon to provide services for these people will demonstrate effectively that the profession will not abuse its privileges under any system of medical services for those "on relief." C. W. MacC.

Letter from Prime Minister to Premiers of Various Provinces

The following communications have been received from the Secretary of the Canadian Medical Association:—

Dr. T. C. Routley, Ottawa, December 12, 1933.
General Secretary,
Canadian Medical Association,
184 College Street,
Toronto 2, Canada.

Dear Sir,—I enclose you herewith a copy of a letter which I have sent to the Prime Ministers of the Provinces.

I regret the long delay. It was occasioned by the necessity of clearing up a possible misunderstanding with one of the Provinces.

Yours faithfully,

(Signed) R. B. Bennett.

Dear Premier Henry: Ottawa, December 12, 1933.

A delegation representing the Canadian Medical Association met me some weeks ago and urged the desirability of the Federal Government providing a portion of the cost of medical aid for those receiving relief in the various Provinces.

It was pointed out to me that many of the Provinces had expressed their willingness to provide for medical services for those on relief, but they alleged that the Dominion Government prevented them from doing so.

It is rather difficult to understand such a statement being made. The responsibility of the Provinces in caring for the sick, by methods which they have themselves determined, cannot be made a Federal obligation. We have contributed to relief, but we have not set up a Federal Relief Commission as some of the Provinces are unwilling to surrender their constitutional rights in that regard.

I pointed out to the delegation that I assumed the Provinces would continue to discharge their obligations to their citizens, but if, from time to time, representations were made in respect to individual communities where it was found that the burden was unduly onerous, the Federal Government would sympathetically consider each case upon its merits and determine whether or not, on the facts stated, it would be warranted in making a contribution to assist the Provinces to discharge their normal responsibilities regarding medical and hospital care and treatment.

I intimated to the delegation that I would communicate with each of the Provinces in the sense above indicated.

Yours faithfully,

(Signed) R. B. BENNETT.

Medical Relief

Editorial — Canadian Medical Association Journal

PERHAPS no one problem has engaged the attention of so many members of the medical profession in Canada as has the problem of medical relief, particularly during the past year or more. The term medical relief requires interpretation. It means, in my judgment, the provision of adequate medical care for persons on relief and their dependents, and should further mean the provision of this care in a manner which does not impose a hardship upon the purveyors of that care, namely, the medical profession. The question, too, has given rise to a certain amount of misunderstanding within the profession. There are a number of physicians to whom the term suggests synonyms of State Medicine, Health Insurance, etc., etc. It should be clearly understood by all concerned that medical relief during the present national emergency means just what it says and no more, namely, the provision of medical care for those who ordinarily provide this care for themselves, but at the present time are unable to do so. It is most important that we do not accept the abnormal condition as something upon which we must base a solution for normal conditions.

The Good Book says, "The poor we have always with us", and perhaps no one is better qualified to vouch for the accuracy of that statement than is the medical profession. It has been traditional for the profession throughout the long years to care for the poor without hope of gain or reward. But again we must insist, even risking the danger of over emphasis and repetition, that medical relief is not a term applicable to the "normal poor", if one may be permitted to use such an appellation.

The Government of Canada, to its credit, accepted the responsibility of providing funds to the several provinces of Canada to be used for general relief purposes during the present emergency. It should be pointed out that the Federal Government was under no legal obligation to do any such thing.

The British North America Act makes this point very clear, and it is well that we should all understand this as a basis for what follows. The Federal Government felt it to be a moral obligation to assist the provinces, and with that end in view has contributed a great many millions of dollars during the past three years. In handing over sums of money to nine administrative bodies, it did not seem unreasonable that the Federal Government should set up a policy or a set of rules governing the expenditure of this money, and, therefore, it was laid down that, upon the presentation of the proper vouchers from the respective provinces, the Federal Treasury would reimburse the provinces to the extent of one-third of the cost incurred in providing food, fuel, shelter and clothing. Just here it should be interpolated that, while the Federal Government set up those four main conditions of expenditure in which it would participate, it did not say at any time that these four obligations in any sense represented the entire obligation of a provincial government to its people.

Acting on behalf of the Provincial Medical Associations of Canada, the Canadian Medical Association made representations to the Right Honourable the Prime Minister of Canada that medical care was just as important for a family on relief as food, fuel, shelter and clothing. The Prime Minister of Canada did not take issue with this contention, but, on the contrary, agreed with your representatives that such was the case. He further stated that because the Federal Government had not included medical care in the list of expenditures to which it would contribute it could not be argued fairly that the Government had placed any prohibition against the suggested supplying of medical care by the provinces. Indeed, the Prime Minister in no uncertain terms told your delegation that it was the duty of every provincial government in Canada to provide medical care, and again he pointed to the British North America Act as the determining factor in this. He further stated that the medical profession should not be asked to carry the entire burden and provide the necessary care but that they should be paid in whole or in part for their services.

It was the privilege of the General Secretary to consult with six of the nine provincial governments of Canada, and to obtain from each of these six governments a definite statement to the effect that medical care should be provided persons on relief, and that the medical profession should be paid for their services. Tacit agreement to this statement may be said to have been forthcoming from two of the remaining three provinces. One province, through its Medical Association, disclaimed all interest in the problem. No advice was received from the government of that particular province. From the foregoing facts, it would seem that the following statements are correct:—

1. Governmental authority in Canada, nationally and provincially, approves of medical care being included in relief provisions.

2. Constituted authority believes that the medical profession should not be asked to provide this care gratuitously.

3. Organized medicine across Canada has stated its position to be decidedly in favour of the medical profession being paid for services rendered to relief cases.

Now, with these facts established, where does the matter rest at the moment. Only one province in Canada has, at this writing, accepted its responsibility with regard to medical relief. One year ago, the Government of the Province of Ontario announced that it would contribute two-thirds of the cost of medical care, while the municipality concerned paid the remaining third of the cost. In a number of municipalities, the plan has been put into effect and is working satisfactorily. In a great many municipalities

in the Province nothing has yet been done, because these municipalities have refused to accept the Government's offer, for the reason that the municipalities refuse to provide one-third of the cost.

The other provinces, through their respective governments, have, up to the present, taken refuge by saying that unless and until the Federal Government provided one-third of the cost of medical care they could not undertake this additional responsibility. The Prime Minister of Canada says, in reply to the provinces, "Go ahead; assume your rightful responsibility and in the case of those provinces which cannot afford to undertake this additional burden, the Federal Government will be willing to come to their aid with additional funds". Therefore, it is now strictly up to the provincial authorities to institute across Canada the necessary machinery to relieve the medical profession from a burden which, in many instances, has become too great for the doctor to carry. It will likely be found, however, in all of the provinces, just as it has been found in Ontario, that the court of final jurisdiction, namely, the municipal government, can block the whole scheme by declining to accept the offer of its government for funds to pay the doctor. This again would appear to be a legal right which the municipality enjoys as one further heirloom from the British North America Act. Just how each municipality will be compelled to recognize its responsibility, legally, morally and honourably, yet remains to be worked out. The most important court of all, namely, public opinion, can solve that problem and, indeed, one feels quite confident that, if the public were asked to decide the matter, the answer would be speedily and unmistakably given in favour of payment being made for services rendered.

One should not leave this subject without saying a word in regard to the future. It would be most unwise to deal with the present emergency as anything but an emergency. It should be clearly understood that the activities of organized medicine in connection with this problem are not to be construed as having any bearing upon a policy of medical services for normal times. Much has been said and written of recent years in regard to State Medicine and Health Insurance, and, unquestionably, there is a great deal of ambiguity and confusion in both the minds of the medical profession and the public as to the meaning of these terms. The medical profession prides itself in this fundamental of its structure, namely, that adequate treatment cannot be suggested until an accurate diagnosis has been made. As yet, the Canadian Medical Association with the information before it, has not made a diagnosis of the problem of medical care in a manner satisfactory to all the people, and, therefore, is not prepared at this time to offer any cure by way of a plan. We are engaged, through our Committee on Economics, in studying the problem in all its ramifications, and, in due season, the report of the Committee will be made available. Meanwhile, it is well for the profession in Canada to thoroughly understand and appreciate that, while we are observing a policy of watchful waiting and intelligent study, we are not making any attempt, nationally or provincially, to steer the profession or the public into a plan which neither the profession nor the public may find satisfactory. There are many amongst us who argue that the medical profession should of itself evolve a plan for State Medicine or Health Insurance; that such a plan is long overdue; that, if we do not evolve a plan, the public will do it for us. In the opinion of the writer, there is no necessity for the profession to be panicky or uneasy in regard to these contentions. At the same time, common sense would dictate that it behoves us to receive and appraise in an unprejudiced manner any suggestions which are offered from this or any other country dealing with the distribution of medical services.

The Canadian Medical Association, with a history dating back to Confederation, may be trusted to safeguard the interests of the people whom it serves and the profession of which it is constituted in a manner in keeping with the highest ideals and traditions of this young nation of which we are all so proud. —T. C. ROUTLEY.

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The Canadian Medical Protective Association

By W. HARVEY SMITH

AS a member of the Provincial Executive of the Canadian Medical Protective Association, I desire to direct the attention of non-members in Manitoba to the excellent features of this organization, which commences its fiscal year on the first of January next.

The Association was founded in Winnipeg thirty-three years ago, under the auspices of the Canadian Medical Association, with the object of defending civil actions for damages, for alleged malpractice by practitioners of medicine or surgery where such actions appeared to be unjust, harassing or frivolous, and of affording those whose professional skill might be subject to impeachment, first-class legal counsel and defense when brought before a court-of-law, without cost to them.

Since its establishment, the Association has dealt with considerably over five hundred threatened suits for malpractice, a very small proportion of which has been brought to trial owing, doubtless, to the fact that dissatisfied or predatory patients, looking for an opportunity to blackmail or embarrass a physician by the threat of legal process, hesitate to bring suit when they have realized that the object of their dissatisfaction or animosity has behind him a fighting organization, the best legal talent available, wide experience in the handling of malpractice actions, and ample funds with which to defend any of its members who may be charged unjustly with professional negligence or lack of skill.

The value of the Association is well illustrated in the case of one of Winnipeg's leading surgeons, who a few years ago was the victim of a malpractice action which brought him wide publicity and great annoyance. Happily, he was a member of the Protective Association, who fought his case through two courts, won a verdict in his favor, and paid all the costs, which amounted to nearly two thousand dollars.

The value of the insurance principle—spreading the risk—as applied to the hazards of life is universally accepted, but, curiously, large numbers of medical men have failed to protect themselves from malpractice suits; thus the Protective Association has a membership of only twenty-four hundred in the Dominion, of which Manitoba contributes one hundred and seventy-five.

I know of no organization established for the benefit of the medical profession of greater potential value than the Canadian Medical Protective Association, and would urge all who are not already members to join without delay. Membership is available to any qualified physician of the regular school at an annual cost of five dollars. Application forms can be obtained from the Secretary, Dr. J. Fenton Argue, Ottawa, or the Business Bureau of the Medical Arts Building, Winnipeg.

Amebiasis

By

F. T. CADHAM, B.A., M.D. (Man.) F.R.C.P. (C.)

Professor of Bacteriology, University of Manitoba
Bacteriologist, Department of Health, Manitoba, etc.

AMEBIC DYSENTERY (amebiasis) is a disease considered to be peculiar to tropical and subtropical countries. It is prevalent in India and Egypt, and is common in the southern part of North America. Sporadic cases do occur in the temperate zones, and more frequently than is generally recognized. The disease is uncommon in Canada, and has never existed in this country in epidemic proportions. During the past ten years I have seen fourteen patients, residents of Manitoba, who suffered from the infection.

At the present time there exists throughout Central North America a widespread epidemic of amebiasis.

Between August 1st and 15th of this year four cases of amebic dysentery were reported to the health authorities of Chicago. This was three times the normal evidence. Investigation showed that each of the patients had partaken of meals at a certain hotel. Further investigations were carried out on the food handlers in this hotel, and by the time the investigation was completed, it was found that apparently tweny-five per cent. of over 300 food handlers were infested with the causative parasite, the Endamœba histolytica. It is stated that of this group, two, one a cook, had been implicated in 1927 in a small epidemic of this disease that had occurred in another Chicago hotel.

From August to November 1st, one hundred and eighty-five cases of the disease had been reported in Chicago, with nineteen deaths, and four hundred cases were noted from other parts of the Central and Northern states. Since 22,000 guests had registered at the hotel in question during the past summer, the number of reported cases probably represents but a fraction of those infected. Moreover, the incubation period is from 9 to 90 days, so, no doubt, many of the infected persons are in the incubatory stage of the disease. Furthermore, each infected person becomes a potential source for a further spread of the disease. Secondary cases are now being reported.

A diagnosis based entirely on clinical symptoms may be difficult. The disease occurs in the mild, acute, and chronic forms. The symptoms also vary with the stage of the disease, with the individual, and with the virulence of the strain of Endamœba histolytica with which the patient is infected. The acute form is frequently noted during the present epidemic. The onset is sudden and characterized by severe abdominal pain associated with tenesmus and a serious diarrhœa. Mucus and blood appear early in the stools. The patient may become weak and depressed. Fever is infrequent, but an elevation of temperature may occur in the acute type.

As a rule the severe symptoms subside within a week. Further mild attacks may recur at intervals and some of these patients become sufferers from chronic amebic dysentery.

A considerable percentage, estimated by some as high as fifty per cent. of the persons infected with the organism develop no symptoms, or symptoms so slight in character that they pass unheeded. In a further group of cases

the onset is insidious, and the recurring attacks increase in severity. Even in the mild cases the complication of an abscess of the liver may supervene.

A confusion of diagnosis may occur. Reports are published of certain patients who, infected with the amebae in Chicago developed acute abdominal symptoms subsequent to their return to localities where amebic dysentery was unsuspected, and were subjected to an operation for appendicitis. The disease may also be mistaken for bacillary dysentery, ulcerative colitis or peritonitis.

An absolute diagnosis depends upon finding the Endamœba histolytica in the stool. This demands certain technical procedures. The feces should be collected in a clean dry container, and examined within one half an hour, and while warm, preferably within 15 minutes of being passed, for the organisms degenerate quickly after passage, unless they are in the cystic stage of development.

There are five species of amebae that may infest the human intestine, only one of which is considered to be pathogenic, the Endamœba histolytica. These protozoa may be present in the pre-cystic, cystic or vegetative stage. They cannot ordinarily be differentiated in the pre-cystic stage, and only with some difficulty in the cystic stage. In stained preparations the presence of the four round nuclei of a fully developed cyst is characteristic of the Endamœba histolytica.

A true criterion of the presence of the Endamœba histolytica is the demonstration in the stool of an actively motile ameba which sends forth clear finger-like pseudopodia, and contains ingested red blood cells. If only cysts are present, it may be advisable to administer to the patient a laxative of magnesium sulphate, and the stool is subsequently examined for the vegetative forms of the organism. The culture method of diagnosis may be attempted, Bundesen and others report success in detecting carriers amongst the workers of the Chicago hotel, by the application of this method. For culture media they used a liver infusion agar.

Pertinent to the problem of the laboratory diagnosis the following is a quotation from Craig, a leading authority on the subject:

"No diagnosis of amebic dysentery is of any scientific value unless Endamœba histolytica is demonstrated in the stools of the patient, and it is necessary in diagnosis to differentiate this species from Endamœba coli, Endamœba nana, Iodamœba williamsi, and Dientamœba fragilis. In order to do this it is essential that one have a knowledge of the morphology of the parasitic amebae of the human intestine, and of other protozoa occurring in this region, as well as of various vegetable cells that occur in the stools, a knowledge that cannot be acquired by the cursory examination of a few specimens of feces, but is always the result of many months of careful study of the protozoa of the intestine and the experience gained by many errors in the diagnosis of the various organisms that have been encountered."

The infection as a rule is carried by food or water supplies, and the epidemiological problem is largely one of detection and control of infected food handlers, and of the elimination of the possible pollution of water supplies with the parasite. Once infected a person may for years carry and disseminate the cysts of the organism. These cysts when passed show a high degree of resistance to chemicals, and may live for weeks under favourable conditions. When imbibed each cyst liberates in the lower portion of the small intestine of the host an ameba which contains four nuclei; these nuclei again divide, and the parent organism separates into eight small amebulae which develop and produce amebiasis.

In the treatment of amebiasis emetine and stovarsol have long been the remedies of choice; however, following the administration of either, the patient may develop severe toxic symptoms, and continued administration of emetine is considered dangerous. Brown suggests that if the patient is acutely ill that three grains of emetine be administered in divided doses on the first day, two grains in divided doses the next day, and one grain in divided doses on the third day. The best results with emetine apparently are obtained by subcutaneous inoculation. During acute exacerbations of the chronic type of the disease Craig advises the use of emetine bismuth iodide administered orally. Recently Carbarsone, a drug containing 28.8 per cent. arsenic has come into favour; claims are made that it equals emetine in efficiency, and is non toxic. The dosage of Carbarsone is stated to be 250 mg. in gelatine capsules twice daily for ten days, or a total dose of 5. grams. Confinement to bed may be necessary, and a proper bland diet is of great importance. The disease can only be considered as cured when there is a permanent disappearance of the amebae from the stools.

A regulation of the Board of Health of Manitoba makes amebiasis a notifiable disease. We may not see immediately many cases in the province. During the past year travel and high class hotels were beyond the economic reach of the great majority of the residents of this part of the country, and few were subjected to the possibility of infection at the Chicago focus. However, conditions have been established for an extended epidemic; the hazard now exists in practically every State and Province, and physicians should make themselves conversant with the symptoms of the disease.

OBITUARY

Dr. Herbert P. Byers, November 24th, 1933

THE passing of Herbert Byers severs a tie with the early pioneering days of south-western Manitoba.

Born near Sheffield in Yorkshire, England, on September 17th, 1860, he received his school education at King's Lynn and Manchester, and then commenced, at Leeds, his long association with medical practice. There, as was the custom in those days, he was apprenticed to a general medical practitioner and also attended the hospital service, already famous for the early work of Clifford Allbutt.

In 1882 he came to Manitoba and for some years was active in the survey of Western Canada. Resuming his medical studies, he graduated with Gordon Bell in the class of 1890. He then went out to the new settlement of Melita, at that time a small collection of tents on the hill to the west of the present town. Here, save for six years at Selkirk—from 1895 to 1901—was the scene of his life's work. For many years he was a keen cricketer, excelling in his ability behind the stumps; indeed, to him may truly be given the highest praise desired by an Englishman, that of having played cricket all the days of his life. Though, after his return to Melita, he took little part in the affairs of the province outside his own area, this was due to his devotion to his task; to bring his very best to the ease, comfort and health of his people, and to keep himself abreast of modern advances. True to his type, he seldom used the knife, but left the surgical treatment of his patients to those of his colleagues who were more recently trained and more accustomed to the art, but generations bless him for his skill in diagnosis, his wise choice of treat-

ment, and for his ever gentle and diligent care. No journey was too difficult for him, and pecuniary reward was his last thought. In his association with those who succeeded each other in sharing with him the medical service in Melita and south-western Manitoba, he was in all but name the very pattern of the elder partner. During the past few years, the increasing difficulties of practice in that sore-stricken area weighed heavily upon him, and it was distressing to note the loss of elasticity in his step, which until after his seventieth birthday was so marked a characteristic. It was with difficulty that he was finally persuaded to drop his activities and to retire to a residence in Brandon. For many years he held the appointments of Health Officer of Melita and the Municipality of Arthur, of Coroner, and of Medical Officer to the Canadian Pacific Railway.

In his family life he was most happy. In 1886 he married Miss Anne E. Pruden of Selkirk, and by this union had three children, of whom Constance and Fred survive him. His first wife died in 1916. In 1918 he married Miss Edna Irvin, of Morden, by whom he is survived, and also by their three children, Harold, Betty and Peggy. He was ever a faithful member of the Church of England, and was affiliated with the Sons of England. The service at Brandon on November 27th was conducted by his old friend, Bishop Thomas, and his remains were taken to Melita and laid beside those of his first wife and their child.

At Brandon, the Manitoba Medical Association was represented by Dr. T. A. Pincock; the Brandon Medical Society by Dr. H. S. Sharpe and Dr. N. R. Rawson; the Sons of England by Bro. A. Veale, Grand President of Manitoba, and Bro. G. N. V. Davis, President of the Brandon Lodge. At Melita, the funeral arrangements were made by the local Lodge of Sons of England, of which the Doctor had been a member for many years. It seemed as if the whole district turned out to pay a last tribute of love and affection.

—Noel R. Rawson.

News Items

— of —

Department of Health and Public Welfare

Winnipeg, Manitoba,
January 1st, 1934.

Dear Doctor:

The year 1933 has been a difficult one for almost everyone, particularly the members of the medical profession, but as it draws to its close we are mindful of the many things for which we have reason to thank the profession.

We are truly grateful for the spirit of confidence and good-will which has been placed in the Department of Health and Public Welfare and we hope that we will continue to merit your co-operation in the future. It is this hope and the faith we have in our people which make our work worth while and give us encouragement to carry on in 1934.

To all we extend the Season's Greetings and very cordial best wishes for a New Year full of attainment, satisfaction and prosperity.

Yours very sincerely,

R. A. HOEY,
Minister of Health and Public Welfare.

The Medical Examination of the Child Entering School

The following is an article written by Doctor Louis C. Schroeder and published in *The Health Examiner*, which we thought would be of interest to our readers:—

The debt which medicine owes to its sister sciences must be repaid wherever possible. To continue to receive the benefits of research in allied fields and to fail to give to others, especially to those interested in health but not medically trained, is to exhibit a selfishness entirely out of keeping with the best traditions of our profession.

For a number of years the science of pedagogy has been asking for help from medicine. Teachers everywhere are keenly alive to the importance of healthy bodies and stable emotions in their pupils and of the necessity of teaching good health practices, for they know that the very best curricula and the soundest methods of training are never fully effective when the material with which they work is below par.

Some attempts have been made to bring about a closer union between medicine and pedagogy, as witness the joint committee of the American Medical Association and the National Educational Association, but as is so often the case, without the active interest of the majority of physicians the movement has gone by fits and starts and has not obtained the momentum which it deserves and which is necessary before it can be considered successful.

As doctors, parents and taxpayers, it can truthfully be said that we should be more interested in our schools than any other class of citizens. Our duty is plain. No matter how wide the range of medical interests has become, no matter if it is necessary for us to know something about the pituitary control of the ovarian cycle as well as the best method of handling an ingrowing toe nail, the obligation of seeing that the school population is free from physical defects, free from emotional quirks that may later lead to psychopathic states and free from, or as little hindered by mental retardation, that has a basis in organic disease or physical defect—lies more heavily on us than it does on anyone else.

We can do this particular job, and no better start can be made than by seeing that every child entering school has had the benefit of a thorough physical examination. Raymond Frazen in School Health Research No. 5 published by the American Child Health Association states that the first distinctive element in a school health program is "adequate examination" and he adds significantly: "We are not able to set up examples of adequate examination in order to observe their effects."

Here is a challenge thrown directly into our teeth. Two things are necessary before we can meet this challenge squarely. First, there must be a wider participation by physicians in the program to have children entering school for the first time examined and second, there must be an agreement among us as to what constitutes an adequate examination.

The first has a sociological angle and can be best handled by the County Medical Societies. The second is a problem for the individual physician and with this the present paper is chiefly concerned.

Let us state very frankly that it is our honest belief that any trained physician can make an adequate examination. The difficulty does not lie there but rather in our failure to fully appreciate where the emphasis must

be laid and that what we are after is the detection of incipient disease or defect combined with the opportunity to lay down the law regarding daily hygiene of body and mind.

If there is a main object behind the plan to examine all children who are to enter school, it is to see that they are all free from remediable physical defects. Here we immediately come a cropper because of the divergent views held by competent men as to what should or should not be done regarding such procedure as the removal of tonsils.

Looking at tonsils doesn't always solve the problem, but that combined with a history of repeated upper respiratory troubles and the detection of even slightly enlarged cervical nodes should settle the question correctly. Here the emphasis is not on the tissue in question, because with the tonsils this too often betrays us but rather on a good history and the examination of adjacent lymph nodes. To be sure the emphasis may be on the tonsils because of their size or diseased condition but in those cases physicians rarely disagree. Disease of the paranasal sinuses even at the age of five or six is not a Frankenstein created by the rhinolaryngologists. Frequent colds especially with a history of continued profuse nasal discharge should emphasize the need of transillumination or x-ray rather than silver drops into the nose.

The determination of the nutritional status and physical growth of children is not difficult though it is not quite so simple as reading it from a height and weight chart. To the credit of physicians it can be said that very few ever subscribed whole-heartedly to the idea of charts but the disquieting thing, which is true but not often acknowledged, is our almost complete failure when we judge by merely looking at an undressed child.

There are fat children and thin ones, but the emphasis is not to be placed on either fat or leanness, but rather on skeletal build. We must learn to make allowances for the skeletal build as many cases who are seven to ten per cent. underweight by the tables are perfectly normal when compared to their peers in depth and breadth of chest and hips.

It has been abundantly proved that our errors in judging nutrition are less when we consider the girth of the arm as the best single index. This combined with the size of the calf and the amount of subcutaneous fat over the biceps and triceps serve us so well that if we emphasize them we cannot but prove ourselves efficient and accurate.

Granted that the diagnosis of malnutrition is beset with certain difficulties due to our lack of accurate data, what should be the procedure if the diagnosis be made? Disease must of course be ruled out but the emphasis is not placed there because disease, as a cause of malnutrition, does not bulk as large as errors in diet, lack of sunshine, overstimulation producing fatigue, whether it be the movies, late hours, frequent auto rides or disturbed sleep. It is placed rather on the history with especial attention to the minutiae of the child's daily life, especially his food habits.

Let us not become disgusted with the commercial exploitation of foods—the advances have been real and unquestionably our children are better off with a little less cereal and considerably more green vegetables and fruit. The history, as a matter of fact, is much more likely to put one on the right track than is the physical examination as far as disease is concerned. Tuberculosis, seldom a true producer of wasting in childhood, is usually diagnosed by a skin test and x-ray; rheumatism as an active disease only begins to assume importance about the time children enter school but a careful history, bearing in mind the importance of indefinite joint and muscle pain and sore

throat, will lead to the detection of incipient cases; proving that it can start much earlier than is usually thought to be the case.

Posture, impaired hearing, defective vision and dental caries have never received the attention from physicians which their importance deserves. No examination of a child getting ready to enter school should fail to give all of them their just due. To teachers these defects have an importance that is sometimes difficult for a physician to understand. If he were to consider for a moment how necessary it is for a child to hear what the teacher says and to see what is put upon the blackboard and if he were further to remember that each of these youngsters acts as a drag on the other children and if he could but have the practical experience of seeing some of these handicapped children develop genuine psychoses because of their physical infirmities, he would agree that teachers know what they are talking about. The detection of poor posture is so simple, if a physician has it in mind, that although his own knowledge of body mechanics may leave much to be desired, the age element is so favorable that much can be accomplished by attention to the correct methods of standing, walking and sitting. A Snellen chart for illiterates will solve the problem of testing the sight of those children who have not learned their letters, while in a quiet room with a watch or the whispered voice those whose hearing has been impaired can be easily detected.

Just what part the general practitioner will finally play in the matter of mental hygiene for children is still in the laps of the Gods. To those men who are psychiatrically minded the opportunity to consider the causes of negativism, temper tantrums, jealousy, asocial habits and the rest of the problems associated with the emotional maladjustments so often encountered in families is welcomed. It is feared that too small a percentage of the profession is so inclined and more's the pity.

Common sense would seem to demand that this condition be changed. It is now acknowledged that many children never grow out of their early difficulties. The person who should assume this responsibility is the general practitioner. He need not subscribe entirely to all the psychiatrists and psychologists write about, but he can have an intelligent curiosity and should know where to get intelligent help.

No attempt has been made to outline exactly, step by step, the routine examination of children getting ready for school. The need for it we trust has been sufficiently emphasized and the benefits far exceed the mere giving of help to teachers, because after all what we are doing is laying the foundations for successive generations of children each of which in turn is healthier than its predecessor and the possessor of a correspondingly greater content of health knowledge and the practitioners of a daily hygiene that in time will be ideal.

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COMMUNICABLE DISEASES REPORTED

Urban and Rural : November, 1933

Occurring in the Municipalities of:—

Chickenpox: TOTAL 383—Winnipeg 248, (delayed report: Brandon 31), St. Boniface 21, Kildonan East 19, Brandon 15, St. James 9, Hamiota R. 8, Portage la Prairie City 8, Whitemouth 5, Cypress N. 4, Stonewall 4, Hamiota T. 2, Kildonan W. 2, St. Vital 2, Daly 1, Eriksdale 1, Strathclair 1, Whitewater 1, Rossburn T. 1.

Whooping Cough: TOTAL 217—Unorganized 77 (late reported), Winnipeg 76, Birch River 17 (late reported), Dauphin Town 19, The Pas 8, Unorganized 5, Portage

la Prairie City 4, Springfield 2, St. Clements 2, (October late report: Springfield 2), Kildonan E. 1, Minnedosa 1, St. Boniface 1, Whitemouth 1, (October late report: Chatfield Unorganized 1).

Scarlet Fever: TOTAL 134—Winnipeg 31, St. Boniface 21, St. Vital 14, Franklin 9, Victoria Beach 8, Woodlands 6, Grey 5, Strathclair 4, Dauphin R. 3, St. Clements 3, Elton 2, Harrison 2, Rockwood 2, Unorganized Miscellaneous 2 and Sprague 2, Argyle 1, Gilbert Plains T. 1, Grandview R. 1, Kildonan East 1, Kildonan North 1, Kildonan West 1, Killarney 1, Minitonas 1, Morris R. 1, Stanley 1, Stonewall 1, Ste. Anne 1, St. Andrews 1, St. James 1, Winkler 1, (October late reports: Rockwood 3,. Unorganized 1, Woodlands 1).

Diphtheria: TOTAL 63—Winnipeg 35, Morden 8, Strathclair 3, Franklin 3, St. Andrews 2, St. Boniface 2, The Pas 2, Birtle Town 1, Dauphin R. 1, Fort Garry 1, Whitemouth 1, (October late report: St. Andrews 4).

Tuberculosis: TOTAL 63—Winnipeg 14, Unorganized 7, Dauphin T. 2, Harrison 2, Springfield 2, Stanley 2, St. Boniface 2, St. Clements 2, Stuartburn 2, Bifrost 1, Boulton 1, Brenda 1, Brokenhead 1, Carman 1, Coldwell 1, Cypress South 1, Dufferin 1, Ellice 1, Franklin 1, Grey 1, Kildonan East 1, Miniota 1, Oak Lake 1, Oakland 1, Pipestone 1, Plum Coulee 1, Ritchot 1, Rockwood 1, Roblin T. 1, Stonewall 1, Strathclair 1, St. Andrews 1, The Pas 1, Transcona 1, Kruezberg 1, Westbourne 1, Whitewater 1.

Mumps: TOTAL 21—Winnipeg 13, Brandon 5, Ethelbert 1, Saskatchewan 1, St. Boniface 1.

Typhoid Fever: TOTAL 7—Morris R. 2, Dauphin T. 1, Eriksdale 1, Rosser 1, Woodlands 1, Winnipeg 1.

Diphtheria Carriers: TOTAL 7—Winnipeg 5, Bifrost 1, Fort Garry 1.

Erysipelas: TOTAL 5—Brandon 1, Carman 1, Dufferin 1, Hanover 1, Winnipeg 1.

Septic Sore Throat: TOTAL 3—Shell River 2, Silver Creek 1.

Influenza: TOTAL 2—Gimli Town 1, Winnipeg 1.

Lethargic Encephalitis: TOTAL 2—Winnipeg 2.

Trachoma: TOTAL 2—Unorganized 2.

Cerebrospinal Meningitis: TOTAL 1—Winnipeg 1.

Measles: TOTAL 1—Lac du Bonnet 1.

Puerperal Fever: TOTAL 1—Unorganized 1.

Amœbic Dysentery: TOTAL 1—St. James 1.

THE MEDICAL LIBRARY

ITEMS MISSING

The librarian wishes to acknowledge the return of the following items, which were listed in the October number of the *Bulletin*:—

Book: Walker, Kenneth—"The Enlarged Prostate."
Returned October 31, 1933.

Journal: "American Journal of the Medical Sciences." Jan., 1933.

The following items listed as missing have not yet been returned:—

Walker, Kenneth—"Male Disorders of Sex."

Gould, Sir Alfred P.—"Elements of Surgical Diagnosis." 7th ed.

It is hoped that these may be returned without further delay.

The following two new items are reported missing, the return of which will be appreciated:—

Clark—"Applied Pharmacology." 4th ed. 1929.

Herman—"Difficult Labour." 7th ed. 1929.

Tissue Diagnostic Service

By the Cancer Relief and Research Institute

To assist in the diagnosis of malignant disease, the Institute has provided a diagnostic tissue service to doctors practising at outlying points and hospitals which have no pathologist. The fee for this examination will be five dollars, but tissues from patients unable to pay will be examined without charge.

In submitting tissues for examination, doctors are requested to give the patient's name and age, also clinical notes such as the time since the tumor was first noticed, its recent rate of growth, its present size and gross characteristics.

While small bits of tissue are usually adequate for histological diagnosis of rodent ulcers, in other forms of malignancy a generous piece including some subjacent tissue is desirable.

Specimens should be immediately placed in five per cent. formalin and address to the Cancer Relief & Research Institute, Medical College, Winnipeg.

Grace Hospital Clinical Luncheon

THE last of these luncheons for the year was held at the hospital on December 19th, when a goodly number of doctors from the city and a few from nearby country points attended.

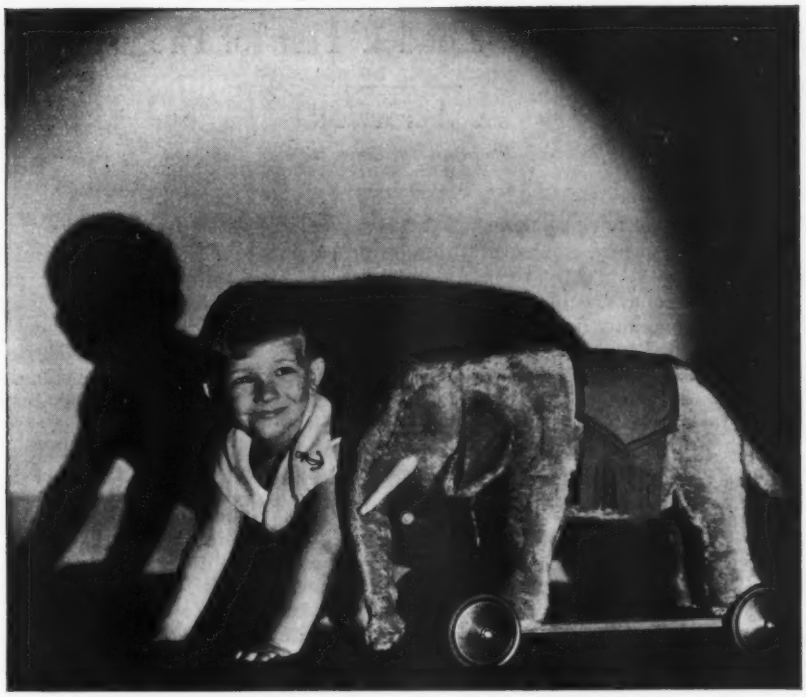
The programme was of marked interest and highly instructive. Dr. G. C. Dodds presented three cases of Pyelitis of Pregnancy, one due to blockage of the ureter by a stone. Dr. H. D. Morse led in the discussion of these cases, bringing out several important points.

Dr. S. Kobrinsky and Dr. P. B. Grant presented a patient with an enormously enlarged thyroid which had become toxic, and which had caused considerable embarrassment at the time of labor. Dr. G. S. Fahrni led the discussion re. thyroid complication of pregnancy, reporting a series where thyroidectomy had taken place during pregnancy. Children born of these patients were reported to have done well and, contrary to the general opinion held by the laity, in no case had they shown any developmental abnormality.

A report for case of Vagitis Uterinus was left over until a subsequent meeting.

The hospital authorities are endeavoring to develop these clinical luncheons chiefly for the discussion of obstetrical interest. All physicians are cordially welcomed. The meetings are held on the third Tuesday of each month, at 12.30 noon. —F. A. B.

"It is the history of kindness that alone makes the world tolerable. If it were not for that, for the effect of kind words, kind looks, kind letters, multiplying, spreading, making one happy through another and bringing forth benefits, some thirty, some fifty, some a thousand fold, I should be tempted to think this life a practical joke."—R. L. Stevenson.



THE CHILD AND THE ELEPHANT HAVE THIS IN COMMON

THE ELEPHANT, they say, never forgets.

While it's hardly accurate to say that a child *never* forgets, he is very likely to cling to the memory of an unpleasant experience—of a dose of distasteful medicine, for instance. And he's likely, from then on, to turn bitter eyes toward the doctor who prescribed that medicine.

Today, Parke-Davis Haliver Oil products are saving many a doctor from such resentful looks. Because of its great potency, Haliver Oil can be given in friendly drops or tiny tasteless capsules. These small doses do the work of teaspoonfuls of cod-liver oil.

And, of course, Haliver Oil is proving just as helpful in the treatment of adults. No doctor need be told how child-like a full-grown man or woman can act in the face of distasteful medicine. Haliver Oil makes it easier to cope with them, too. In fact, Parke-Davis Haliver Oil products have simplified and solved the troublesome question of how to administer vitamins A and D scientifically and at the same time pleasantly.

Parke-Davis Haliver Oil is supplied in two ways:* either with Viosterol or Plain. Practically every druggist in the Dominion carries these products in stock.

* HALIVER OIL WITH VIOSTEROL-250 D
Containing 32,000 vitamin A units (U. S. P. X.) and 3,333 vitamin D units (Steenbock) per gram.

HALIVER OIL PLAIN
32,000 vitamin A units (U. S. P. X.) and 200 vitamin D units (Steenbock) per gram.

PARKE, DAVIS & COMPANY
The World's Largest Makers of Pharmaceutical and Biological Products

The Friedman Modification of the Aschheim-Zondek Test for Pregnancy

A. T. CAMERON

Professor of Biochemistry, University of Manitoba

OF all the tests for pregnancy that have been suggested from time to time, none has so secure a scientific foundation as that of Aschheim and Zondek. When pituitary implants are made daily for some time into young immature animals, the gonads, and through them the secondary sex organs, are stimulated to precocious development. In the female, the ovaries are enlarged, due to increased number of normal follicles and of corpora, with superovulation. Extracts of pituitary also produce this effect. Aschheim and Zondek found that the urine of pregnant women contained a principle which produced such changes in immature mice, and believed it to be the pituitary principle which they had termed prolan. From this observation, they developed the test for pregnancy which bears their name.

There is now substantial evidence that this principle of the urine of pregnancy — Aschheim's and Zondek's prolan — is identical with Collip's A-P-L (anterior-pituitary-like) principle, which he obtained from human placentæ. This appears to be formed in the chorionic villi, and its production by this tissue accounts for the fact that the Aschheim-Zondek test gives a positive result in all cases where there is a definite amount of living chorionic tissue in the organism, either intrauterine or extrauterine. Such cases include not only normal pregnancy and tubal pregnancy, but also hydatiform mole and chorionepithelioma, and even the rare condition termed teratoma of the testicle.

The original Aschheim-Zondek test was carried out on female mice. A morning sample of urine from the patient for whom the diagnosis was required was extracted with ether to remove substances toxic to mice, and six 0.3 c.c. doses were injected in a 24-hour period into each of five young mice of age and weight within rather definite limits. The animals were killed 100 hours after the first injection. If at least two animals exhibited positive results, the test was considered positive. These positive results were the presence of "blood points" (corpora hæmorrhagica) and one or more corpora lutea in the ovaries, and a uterus filled with fluid. In 1931 Zondek summarized the results of this test as reported by thirty groups of observers. The error in 5,500 tests lay between one and two per cent. The disadvantages of the test lie in the use of mice and the breeding and keeping of a fairly large stock so that enough of the right size and weight are always available, the delay of five days between test and result, and the frequent necessity for microscopis examination of the ovaries of the test animals.

It is now generally agreed that, of the various modifications of the test that have been tried out, that of Friedman and Lapham, published in 1931, is the best. Friedman's test requires rabbits. It is almost or quite as accurate as the test with mice. Its advantages over that test are that female rabbits over a wide range of age can be used, microscopic examination of the ovaries suffices, and the result is available in two days. The chief disadvantage is that a stock of female rabbits must be kept available, which have been individually segregated for at least three weeks.

The test depends upon the fact that in the rabbit the stimulation to ovulation—which normally is given through the pituitary—needs the prior stimulus of copulation. Hence, adult female rabbits, kept apart from both males and females for at least three weeks (so that pregnancy and pseudo-pregnancy in them can be excluded or controlled) have ovaries in correct condition for the test. Urine, preferably fresh (although urine preserved in toluene can be used) is injected into an ear vein. The amount varies a little in different laboratories, but usually two, injected 12 or 16 hours apart, are given. The animal is either killed or anæsthetized, and the abdomen opened at the end of 48 hours, and the ovaries examined for the presence of corpora hæmorrhagica and corpora lutea. The presence of one or more corpora hæmorrhagica indicates that the test is positive.

In analyzing a positive result, the clinical history must be carefully considered, for it must be borne in mind that, while all cases of pregnancy should give such a result, yet a certain minimum amount of the principle must be present in the urine and therefore a certain minimum amount of chorionic tissue must be functioning. Hence, while the test yields satisfactory results from the earliest weeks of pregnancy, it is doubtful if the result will be definitely positive until the end of the first week, so that tests made immediately after the first missed period are sometimes negative. Positive results may be obtained after incomplete abortion and after missed abortion. They should be obtained in cases of ectopic pregnancy, in cases of hydatidiform mole, and, very markedly, in cases of chorionepithelioma. Cases with dead ovum should give a negative result.

In almost all the larger cities on this continent, this diagnostic test is now available and appears to be used extensively. Winnipeg is one of the few exceptions. Present financial difficulties make it hard to establish laboratory facilities for it here at the moment, although it is hoped that they can be overcome in the very near future.

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The following communication has also been received:—

To the Editor of the Bulletin.

SIR. — Following the lucid explanation by Professor Cameron of the Aschheim-Zondek test and the Friedman modification, may I point out the extremely far-reaching character of the physiological principles underlying the test, and its value to the profession at large. The test illustrates the fact that pregnancy affects not merely the reproductive tract, but the whole maternal organism. While the diagnosis of pregnancy is usually easy, there are many cases, especially in the early months, when diagnosis is extremely difficult, or impossible. Obesity, fibroids, or ovarian cysts obscure the diagnosis. In such pathological states as heart disease, chronic nephritis and acute tuberculosis, pregnancy is a grave complication, and an early diagnosis might be of great value. The differential diagnosis between ectopic pregnancy and other intra-abdominal lesions, such as torsion of the pedicle of an ovarian cyst, salpingitis and appendicitis is often difficult. Then, too, the test is markedly positive in hydatidiform mole, and extremely so in chorionepithelioma, enabling an early and positive diagnosis of these serious conditions to be made. To any practitioner who is concerned with the diagnosis of pregnancy, and this means ninety per cent. of the doctors of Manitoba, it may be a matter of the utmost importance to have available a test, already tried and proven, carried out here in such a way as to ensure the reliability of the results.

(Signed) Ross MITCHELL.

Western Canada Medical History

by Ross Mitchell

Medical Relief for Indigent Patients One Hundred Years Ago

Through the kindness of Mr. Osborne Scott, General Passenger Agent, Canadian National Railways, whose father, Archdeacon Scott, was one of the pioneers of this country, we are enabled to give a transcript of certain minutes of the Council of the Northern Department of Rupert's Land.

In Resolution 90 of the meeting of the Council of 1830, and Resolution 80 of 1837 and succeeding resolutions it will be seen that those in authority in this country one hundred years ago—and they were not without marked ability—made far better provision for the payment to medical men for services rendered to the indigent than do the authorities of the present day.

Minutes of Council 1830

MINUTES of the Council held at York Factory: Northern Department of Rupert's Land which commenced on the third day of July, 1830, for the purpose of establishing such Rules and Regulations as may be considered expedient for conducting business of said Department and in order to investigate the results of the trade of last year, and determine the Outfits and general arrangements for the trade of the current year conformally to the provisions of a Deed Poll, under the seal of the Governor and Company of Adventurers of England trading into Hudson's Bay bearing date the twenty-sixth day of March, 1821, at which were present the following Members, viz.:—

George Simpson	Governor-in-Chief
Colin Robertson	Chief Factor
Alexander Stewart	" "
John Clarke	" "
John D. Cameron	" "
John Charles	" "
John Stewart	" "
Alexander Christie	" "
William McKintosh	" "
John Rowland	" "
P. W. Dease	" "
John Lee Lewes	" "
Roderick McKenzie	" "

Resolved 1. That Chief Traders be invited to attend and in consequence the following were present, viz.—

Duncan Finlayson	Chief Trader
Robert Miles	" "
John E. Harriott	" "

Resolved 90. That Richd. Juln. Hamlyn, Surgeon to the Red River Settlement, *be allowed the sum of* 50 *pounds sterling for medical attendance and advice* at the Company's Establishment and to their retired servants at Red River Colony and Neighboring Districts for the following year.

Minutes of Council 1833

Minutes of a temporary Council held at Red River Settlement, Northern Department of Rupert's Land, in consequence of Governor Simpson being

unable to attend at the usual seat of Council through indisposition which commenced on the 1st day of June, 1833, at which were present the following members, viz.:—

George Simpson .....Governor-in-Chief
J. D. Cameron.....Chief Factor
Alexander Christie ..... " "
James McMillan ..... " "

Dr. Bunn having attended professionally on many retired Servants in Red River Settlement *who on account of their indigent circumstances could not pay for medical advice* and having likewise administered medicine at several of the Company's Establishments and to the families of Gentlemen belonging to the Service who have been sent to Red River for the benefit of religious instruction and education during the past year; It is Resolved 89. That in consideration of, and a remuneration for such medical advice and attendance a grant of £50 be made to the same Dr. Bunn for the year terminating the 1st June, 1833.

Resolved 80. That an allowance of £100 be made to Dr. Bunn for medical attendance on the Honble Company's Establishments at Red River, *the retired servants who cannot afford to pay for such and other pauper settlers for the Current Outfit.*

The last resolution was repeated each year until 1843.

Notes on Persons Mentioned

SIR GEORGE SIMPSON.—Governor-in-Chief: the first Governor of the Hudson's Bay Company after the amalgamation of the Hudson's Bay Com-

pany and the North-West Company in 1821. He served as governor of Rupert's Land from March, 1821, till his death in 1860, and was knighted by Queen Victoria in 1839. He made Norway House the centre of administration for Rupert's Land. Mrs. Simpson, sister of the wife of Chief Factor Duncan Finlayson, accompanied him to Norway House for the meeting in July, 1830.

COLIN ROBERTSON was formerly in the employ of the North West Company, but entered the Hudson's Bay services and served as agent for Lord Selkirk from 1812 when the Selkirk settlers came to the Red River.

ALEXANDER CHRISTIE served the company faithfully for thirty-eight years, retiring in 1849 to Edinburgh. He was largely responsible for the erection of the stone fort erected at Lower Fort Garry in 1831. He was twice Governor of Assiniboia, that is the district for fifty miles about the confluence of the Red and Assiniboine rivers. The Christie family, of which Alexander Christie was the head, has given over two hundred and forty years' service to the Hudson's Bay Company.

JOHN ROWAND was for many years in charge of Fort Edmonton. In Dr. Cheadle's Journal (1863) Mr. Colin Fraser, the H.B. trader at Lake Ste. Ann's, is responsible for the following story: "Said the Blackfeet were much belied. In his experience of 38 years in this country never knew an Englishman injured by them. Several Americans killed. Had spent a summer hunting with the Piegans & was treated like a prince. Once when out with Mr. Rowand, as they were resting in the middle of the day, a body of 200 Blackfeet, naked & in war-paint, moved on to them with fearful yells. Mr. Rowand jumped up & cried out 'stop you villains'; one of the chiefs fortunately recognized him & stopped the rest. They were profuse in their apologies & regrets for having frightened them; many of them actually cried with vexation; they had taken them for Yankees, & would certainly have scalped them if they had not recognized Mr. Rowand; asked permission to spend the night with them & told them not to be afraid of their horses; & they made no attempt to steal."

PETER WARREN DEASE, became Chief Factor in 1828, was associated in 1836-37 with Thomas Simpson, cousin of the Governor, in Arctic explorations.

RODERICK McKENZIE was a cousin of the celebrated explorer and partner in the North-West Co., Sir Alexander McKenzie, and his trusted lieutenant. He had special knowledge of the Athabaska country.

DUNCAN FINLAYSON became Chief Factor in 1832, and seven years later began his five-year service as Governor of Assiniboia.

DR. HAMLYN is mentioned in Sir George Simpson's correspondence as "the strangest compound of skill, simplicity, selfishness, extravagance, musical taste and want of courtesy I ever fell in with." In a letter from Thomas Simpson to Donald Ross written at Fort Garry, March 12, 1831, occurs this paragraph:—"The settlement has been extraordinarily prolific in births this season and sickness and mortality very rare. Dr. Hamlyn, however, seems to find plenty of employment. He has two fine horses and is continually galloping about. He lives right opposite us along side the Bishop's House."

JAMES McMILLAN is also referred to in a letter from Thomas Simpson to Donald Ross dated December 19, 1831: "The Governor (George Simpson) drives tandem at a terrible rate. Mr. McMillan sports a very dashing horse and sleigh, and Dr. Hendry, Mr. Ballenden and I, being all well provided to follow in suitable style."

JOHN BUNN was born in the Red River settlement in 1802, graduated in medicine from Edinburgh University in 1832 and returned to the Red River

where he practised until his death in 1861. Thomas Simpson, writing to Donald Ross on December 7th, 1834, says "Dr. Bunn is beginning to vaccinate since hearing of your foresight and success at Norway House. You ask for some vaccine matter, but I cannot send it, as that brought from Canada has been tried by Dr. Bunn and found useless."

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Thirty-five Years Ago—December 13, 1898

Sir William Jenner, distinguished pathologist and physician-in-ordinary to Queen Victoria, passed away, aged 83; Sir William had been the first to establish the difference in kind between typhus and typhoid fevers.

Dr. Wm. Rogers was appointed house surgeon of the Winnipeg General Hospital.—*Manitoba Free Press.*

Medical Library of the University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. Holland, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

THE NEW ENGLAND JOURNAL OF MEDICINE, December, 1933.

"A Fatal Case of Amœbic Dysentery"—by David A. Scannel, M.D.

—The case history of a man, age 42, whose diarrhoea began on the train while returning from Chicago. From X-rays, a diagnosis of carcinoma of transverse colon was made. This was further substantiated at operation, when a hard slightly nodular mass was found in the transverse colon, with enlargement of adjacent glands. Resection was done, followed by colostomy. The pathologist found the mass due to an ulcer in which amoebae were present.

"Methylene Blue in the Treatment of Urinary Tuberculosis"—by Boris E. Greenberg, M.D., and M. Leopold Brodny, M.D., from the Urological Series, Beth Israel Hospital, Boston.

—A general discussion of modes of treatment of urinary tuberculosis, with special attention to treatment by methylene blue.

THE CANADIAN MEDICAL JOURNAL, November, 1933.

"Tortuosity of the Internal Carotid Artery and Its Relation to Tonsillectomy"—by Joseph L. Jackson, Asst. Professor of Anatomy, University of Manitoba.

—An account of the anatomy, normal and abnormal, of the internal carotid artery, and description of a case in which the artery formed a complete loop situated on the superior constrictor of pharynx, and separated from the tonsil only by that muscle and the capsule of the gland.

"Determination of the Activity of Rheumatic Infections in Childhood" — by R. R. Struthers, B.A., M.D., F.R.C.P.(C.), and H. L. Bacal, B.A., M.D., Montreal.

—The value of sedimentation rate estimations is discussed.

"The Early Diagnosis of Cancer of the Skin"—by D. E. H. Cleveland, M.D., C.M., Vancouver.

—The first of a series of articles specially prepared for the Canadian Medical Association Journal on the early diagnosis of cancer.

THE PRACTITIONER, November, 1933.

"Stone in the Ureter"—by Sir William I. DeC. Wheeler, F.R.C.S.(I.), Surgeon, All Saints Hospital for Genito-Urinary Diseases, London.

"The Delayed Treatment of Peritonitis Complicating Appendicitis"—by John M. Melly, B.M., B.Ch., F.R.C.S.(E.), Instructor in Surgery, University of Michigan Hospital, Ann Arbor.

"Injuries to Knee-Joints"—by W. Eldon Tricker, F.R.C.S., Surgeon, St. John's Hospital, Lewisham, Registrar, Royal National Orthopædic Hospital.

"Chronic Skin Troubles of Toxæmic Origin"—by Alfred C. Jordan, M.D., M.R.C.P.

"Otosclerosis, Its Etiology and Treatment"—by Macleod Yearsley, F.R.C.S.

Greetings From Dr. Cox

Alfred Cox, O.B.E., M.A., LL.D., M.B., former Secretary of the British Medical Association, has sent his greetings to the members of the Manitoba Medical Association in a recent letter to the Editor.

"The receipt of the *Bulletin* . . . . is a pleasant reminder that I am an honorary member of the Manitoba Medical Association . . . . please convey my kind regards and best wishes to the members of the Association. I shall alway be proud of my association with Winnipeg and I look back on the annual meeting there as one of the great events of my life."

As an honorary member of the Manitoba Medical Association, Dr. Cox has always taken a kindly interest in the affairs of the association, and his work in connection with the British Medical Association meeting in Winnipeg is remembered with pleasure by all the medical men here. His greetings will be heartily reciprocated by all members of the Manitoba Medical Association.

Steindorff Microscope for Sale

Steindorff Microscope, almost new, with three eyepieces and three objective lenses, including the oil immersion for bacteriological examinations. Circular mechanical stage, all in good conditon - $50.00.

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Clinical Meetings

At Brandon General Hospital—
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases—
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital—
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Grace Hospital—
3rd Tuesday.
Luncheon at 12.30 p.m.
Discussion of Obstetrical Cases will form a large part of the clinical hour.

At Misericordia Hospital—
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital—
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital—
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

At Victoria Hospital—
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital—
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during College Term.

Winnipeg Medical Society—
3rd Friday, Medical College, at 8.15 p.m.
Session: September to May.

Eye, Ear, Nose and Throat Section—
1st Monday at 8.15 p.m., at 101 Medical Arts Building.

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